Reference Number:	100-29-DD
Title of Document:	Medication Error/ Event Reporting
Date of Issue:	January 1, 2002
Effective Date:	January 1, 2002
Last Review Date:	October 15, 2009 **REVISED**
Date of Last Revision:	October 15, 2009
Applicability:	Regional Centers, DDSN Service Providers of: Residential Habilitation, Day Habilitation, And Prevocation

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Purpose

This procedural directive establishes a standardized definition and reporting system for medication errors/ events in order to improve the health and safety of DDSN consumers. Medication errors/events may occur in Regional Centers or when the following services are being provided to DDSN consumers, Residential Habilitation, Day Habilitation or Prevocation. .

General

The South Carolina Department of Disabilities and Special Needs recognizes that medication errors represent one of the largest categories of treatment-caused risks to consumers. As a result of this, every agency that provides services and supports to people who are medically involved should have a medication error/ incident reporting, analyzing, and follow up capability, as part of their overall risk management program.

The safe administration of medication is an important part of the overall health care program provided by DDSN and its network of service providers. Safe medication administration requires training, experience, and concentration on the part of the person administrating the medication. For this reason, medication administration should occur in an orderly environment and at a time when those administrating medications are not distracted with other tasks.

The National Coordinating Council for Medication Error Reporting and Prevention (NCC MERP) has urged agencies, institutions, and researchers to utilize this standard definition of medication errors. DDSN has adopted this definition. (For more information on NCC MERP, see www.nccmerp.org)

"A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use."

Types of Medication Errors/ Events

According to the above definition, there are some kinds of medication errors that are outside the control of DDSN and its network of service providers (e.g., naming; compounding; packaging etc.). If provider agency staff discovers errors of this type, the pharmacist should be notified immediately in order for corrective action to occur. The types of medication errors/ events that are within the direct control of DDSN and its network of service providers, and therefore of most interest, can be divided into three categories: 1) bona fide or "true" medication errors; 2) transcription and documentation errors; and 3) "red flag" events.

1) MEDICATION ERRORS
   - Wrong person given a medication
   - Wrong medication given
   - Wrong dosage given
   - Wrong route of administration
   - Wrong time
   - Medication not given by staff (i.e. omission)
   - Medication given without a prescriber's order

2) TRANSCRIPTION & DOCUMENTATION ERRORS
   - Transcription error (i.e., from prescriber's order to label, or from label to MAR)
   - Medication not documented (i.e., not signed off)

3) RED FLAG EVENTS
   - Person refuses medication (this event should prompt the organization to make every effort to determine why the person refused the medication. Specific action taken should be documented. Each organization must develop a reporting system for these events)
   - "Near Misses" (i.e., medication error almost occurred)
   - Unsafe circumstances (i.e., that may lead to a medication error in the future)
   - Discarded medication found (i.e., on the floor, bureau, etc. Internal investigation must be conducted to determine the intended use of the discarded medication to insure this event would not lead to a medication error)

Data Collection

In addition to providing a standardized definition of medication errors, NCC MERP has developed criteria to guide the development of databases used to record, track and analyze medication errors or other "red flag" events associated with the administration of medication (i.e. the "Taxonomy of Medication Errors"). These criteria help to determine what information to collect when a medication error or "red flag" event occurs.

DDSN has followed the general guidelines of the NCC MERP "Taxonomy of Medication Errors" in developing the attached Medication Error/ Event Report Form. DDSN Service Providers will be required to develop their own data collection system to track, monitor and analyze medication errors/events.

Proactive Analysis

In order to be consistent with "best practice", medication error reduction efforts should possess the capability for both reactive and proactive analysis. Reactive analyses include efforts to better understand both a specific medication error that has occurred and the analysis of aggregate medication error data. Methods of proactive analysis, on the other hand, include the analyzing of consumer refusals, "near misses" or other unsafe circumstances that may lead to a medication error in the future, and the analysis of errors that have occurred in other systems or settings. Providers are encouraged to categorize the types of errors/ events reported in their analysis. Providers are also encouraged to record the agency's error rate (number of errors divided by the total number of medications passed for a given time period) along with the number of errors/ events. Error rates are not to be used as a substitute for the actual number of errors/ events.

Reporting Procedure

The first person finding the medication error/ event is responsible to report the error or event to supervisory/administrative staff, such as the employee's supervisor, program director, nurse in charge or Executive Director/ Facility Administrator. The immediacy of the error reporting is dependant on the severity of the incident or the organization's internal policy. Depending on the type of error/ event, the supervisor/administrative staff shall use professional judgment regarding whether a call to the prescriber is indicated. The supervisor/administrator may also determine that a "911" call is needed.

1) If the prescriber is contacted, the supervisor/administrator will follow the prescriber's orders, if given, and ensure the orders are well documented, including the name of the prescriber consulted. Only a nurse can take a verbal or telephone order from a prescriber, and the new order should be written on the medical orders sheet with supporting documentation in the Nursing Notes.

2) The person should be observed and monitored for any adverse reactions. These may include changes in behavior, levels of alertness, changes in vital signs, or other physiological responses.

3) Document all findings in the Nursing Notes and follow up with the prescriber as needed.

4) Medication errors/ events that are the result of pharmacy errors should be reported to the pharmacist for immediate corrective action.

5) A medication error/ event resulting in serious adverse reactions must be considered a critical incident and have a critical incident report filled out (100-09-DD).

6) As soon as possible, the person finding the error or identifying the event completes the Medication Error/ Event Report form (see attached) and submits it to the supervisor/administrator (or other "in charge" person who is on duty).

7) Upon receipt of the report, the supervisor/administrative staff reviews it for accuracy, signs and forwards the report to the Director of Nursing, Nurse Consultant, or designee.

8) If the medication error/ event resulted in serious adverse reactions, and was thus considered a critical incident, then the supervisor/administrative staff will notify the Executive Director, Facility Administrator, or designee.

9) The Director of Nursing, Executive Director, Facility Administrator, or designee will assure that all medication events are entered into the provider's medication error data collection system and will assure this data is available to the quality assurance and risk management staff/team for analysis, trend identification, and follow-up activity as needed.

10) DDSN may request all data related to medication error/event reporting at any time or during any of the Service Provider's annual reviews.

Follow-up Activities

The purpose of recording and analyzing medication errors is to create a safer, healthier environment in which DDSN consumers live and work. If medication errors are recorded and analyzed, but no follow-up activities are implemented, then the purpose of the effort has not been achieved.

At the provider level, reactive and proactive analysis of trends should be coupled with appropriate corrective actions. These actions may include, but are not limited to, additional training (including medication technician certification), changes in procedure, securing additional technical assistance from a consulting pharmacist, and improving levels of supervision.
Each provider should adopt a method for documenting follow-up activities such as utilizing memoranda or the minutes of risk management/quality assurance meetings. This information must be included as part of the data collection system related to medication error/event reporting.

Kathi K. Lacy, Ph.D.
Associate State Director
Policy
(Originator)

Eugene A. Laurent, Ph.D.
State Director
(Approver)

Related Policies:
100-09-DD; 100-26-DD
Attachment: **SCDDSN MEDICATION ERROR/EVENT REPORT**

M E M O R A N D U M

September 18, 2009

TO: Official Distribution

FROM: Ann Dalton
Director, Quality Management Division

RE: Revision of 100-29-DD

Departmental Directive 100-29-DD, *Medication Error/ Event Reporting*, has been revised to include information about Provider Medication Error Rates that may be used along with the total number of medication errors/ events. The error rate may be used as a percentage in the provider's data collection system to give a better perspective of the rate of errors vs. the total number of medications passed in an agency. Error rates are not to be used as a substitute for the actual number of errors. Providers are encouraged to use this information to track, monitor and analyze medication errors/ events.

The official review period for comments will end on 10/15/09. Please direct your comments, if any, to me by one of the means of communication listed below:

E-Mail	Mailing Address	Telephone Number
adalton@ddsn.sc.gov	Ann Dalton Director, Quality Management Division SCDDSN PO Box 4706 Columbia, SC 29240	(803) 898-9813

Attachment